Prenatal Care

Appointment Study: A survey by the Infant Mortality Work Group of the Mayor's Advisory Council on Child Health*

The length of time it takes for a woman seeking prenatal care to obtain an appointment, commonly referred to as the "waiting time," can either facilitate or deter her entry into the health care system during pregnancy. A 2-week wait, considered by health care professionals to be a standard that should not be exceeded if the health care system is operating effectively, may enable a woman to make the appointment, whereas a wait of a month or longer could make the need for prenatal care seem unnecessary and discourage her from participating.

In 1990, the New York City Department of Health/Bureau of Maternity Services and Family Planning surveyed the prenatal care clinics using a mailed questionnaire to assess the length of time between a caller's attempts and an appointment; they found that clinic waits for prenatal care appointments were roughly 2 weeks. Although this information reassured us about the system's level of functioning, the methodology posed several problems, such as: 1) Uncertainty about the knowledge of the person completing the questionnaire; 2) the possibility that the reported answer was the standard rather than the actual waiting time; 3) a high nonresponse rate; and 4) even with an accurate reporting, the answer only reflected the clinic experience at the time when the question was asked (waiting times are subject to seasonal variation in demand,

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CHAMP is supported by grants from the Robert Wood Johnson and William T. Grant Foundations to the Medical and Health Research Association of NYC, Inc.

staff turnover, and vacancies). The analysis of the results can be no more than a "biopsy" of the system.

The survey conducted for the Mayor's Advisory Council on Child Health is another biopsy of the system, but one with improvements. It explores aspects of the infrastructure beyond waiting time and includes whether or not Spanish-speaking women can obtain an appointment and whether lack of health insurance interferes with appointment availability. The methodology of this survey, described below, shares with the mailed questionnaire the limitation of the responses reflecting clinic performance for the point in time when the question is asked, but it entirely eliminates the other three problems. Instead of asking clinic officials about waiting time (or whomever is assigned the task of completing the written questionnaire), we asked the appointment clerk directly for an appointment as if we were seeking services ourselves. The results, described below, indicate that the infrastructure of the prenatal care system in New York City is ailing.

Methodology

A telephone survey was conducted from January 6 to 10 and from January 13 to 16, 1992 by the Bureau of Maternity Services and Family Planning, New York City Department of Health for the Advisory Council's Infant Mortality Work Group, to document whether or not providers were accessible by telephone; whether English- and Spanish-speaking women alike could make a prenatal care appointment; and what the length of time was between a first visit to a clinic and actually being seen by a physician. Clinics were categorized as 1) Section 330, federally financed clinics; 2) municipal Health and Hospitals Corporation Neighborhood Family Care Centers (NFCCs); 3) clinics funded by the federal Maternal and Child Health Block Grant; 4) nonpublic clinics, such as free-standing, not-for-profit clinics; 5) municipal Health and Hospital Corporations hospital clinics; and 6) voluntary hospital clinics. (The Section 330 clinics and the clinics funded by the Maternal and Child Health Block Grant constitute nonmunicipal, publicly supported clinics.)

Bureau staff contacted health care providers posing as women within their first trimester of pregnancy (with a positive pregnancy test confirmed at a Health and Hospitals Corporation facility or a Department of Health/Maternity Services and Family Planning free pregnancy testing site) seeking prenatal care. More than 115 providers were telephoned in both English and Spanish and asked four questions:

- Can I get a prenatal care appointment? (If no, why not?)
- How soon can I get the appointment?
- Do I get to see a doctor at that time? (If no, how soon?)
- I do not have any health insurance, is that OK?

Results

As shown in Table I, fewer than half of the English-speaking callers could make an appointment, and only 20% of the Spanish-speaking callers could do so. The municipal hospitals, followed by the voluntary hospitals, were the least accommodating, the major reason being that the woman needed to register or become oriented to the facility before an appointment could be made (municipal hospitals), or the hospital prenatal care clinic was inaccessible by the telephone number in the telephone directory (voluntary hospitals). Further, the public clinics would not accept the result of pregnancy tests administered in the HHC Neighborhood Family Care Center clinics at HHC hospitals or at the Department of Health free-pregnancy testing program.

Twenty percent of the facilities were inaccessible by phone on the initial call because there was no answer, as shown in Table II. This problem occurred most frequently among the Health and Hospitals Corporation-Neighborhood Family Care Centers and voluntary hospital facilities. The voluntary hospitals were also inaccessible because of busy telephone lines (32%). Roughly 15% of the time the nonmunicipal public clinics placed the callers on hold for more than 5 minutes.

Among those women who could make an appointment, the wait between their call and first appointment was approximately 2 weeks, as shown in Table III, for both English-speaking and

TABLE I.

PERCENTAGE OF CALLERS FOR WHOM A PRENATAL CARE APPOINTMENT WAS MADE, BY TYPE OF PROVIDER, AND REASON FOR APPOINTMENTS NOT BEING MADE. NEW YORK CITY, 1992

	TOTAL (N = 115)	SECTION 330 CLINICS (N = 16)	HHC-NFCC* (N = 11)	OTHER PUBLIC CLINIC (N = 19)	NONPUBLIC CLINIC (N = 24)	HHC HOSPITAL (N = 11)	VOLUNTARY HOSPITAL (N = 34)
Could make appointment							
English	46.1	43.8	45.5	63.2	62.5	27.3	32.4
Spanish	21.7	25.0	9.1	42.1	40.9	9.1	5.9
Could not make appointment (English only)							
Reasons							
Busy/no answer	16.5	6.3	9.0	21.0	0.0	9.0	35.3
Register/orient before appointment	19.1	37.5	18.2	0.0	16.7	54.5	32.3
Restricted services	6.1	12.5	0.0	0.0	16.7	0.0	5.9
Money/insurance required	0.9	0.0	0.0	0.0	0.0	0.0	1.0
Their pregnancy test required	10.4	12.5	27.2	15.8	4.2	9.0	2.9

* HCC, Health and Hospitals Corporation; NFCC, Neighborhood Family Care Centers.

TABLE II.
PERCENTAGE OF PROVIDERS INACCESSIBLE TO CALLER, BY REASON AND TYPE OF PROVIDER
NEW YORK CITY, 1992

	TOTAL (N = 115)	SECTION 330 CLINICS (N = 16)	HHC-NFCC* (N = 11)	OTHER PUBLIC CLINIC (N = 19)	NONPUBLIC CLINIC (N = 24)	HHC HOSPITAL (N = 11)	VOLUNTARY HOSPITAL (N = 34)
(English only)							
No answer	20.0	6.3	36.4	15.8	8.3	18.2	32.4
Busy	14.8	12.5	9.1	5.3	4.2	9.1	32.4
Hold more than 5 min	7.8	6.3	0.0	15.8	4.2	0.0	5.9

Source: Prenatal Care Appointment Survey, conducted for CHAMP by Bureau of Maternity Services and Family Planning, New York City Department of Health, January 1992.

* HHC, Health and Hospitals Corporation; NFCC, Neighborhood Family Care Center.

TABLE III.
NUMBER OF WORKING DAYS BETWEEN CALL AND FIRST APPOINTMENT, BY LANGUAGE OF CALLER
NEW YORK CITY, 1992

	MEAN	MODE
Total	9	2
English	9	2
Spanish	11	2

TABLE IV.
MEAN NUMBER OF WORKING DAYS BETWEEN CALL AND FIRST APPOINTMENT, BY PROVIDER
NEW YORK CITY, 1992

	TOTAL (N = 115)	SECTION 330 CLINICS (N = 16)	HHC-NFCC* (N = 11)	OTHER PUBLIC CLINIC (N = 19)	NONPUBLIC CLINIC (N = 24)	HHC HOSPITAL (N = 11)	VOLUNTARY HOSPITAL (N = 34)
(English only)							
Working days							
Mean	9	13	11	6	7	16	13
Range	0–45	2–20	2–25	1–16	0–28	6–26	2–45

* HHC, Health and Hospitals Corporation; NFCC, Neighborhood Family Care Center.

Spanish-speaking callers. Table IV gives the mean number of working days between a first call and appointment by the type of providers: Section 330 (federally financed) clinics required almost a 3-week wait, but all other facilities where an appointment could be made were able to accommodate the caller within 2 weeks. There was, however, a wide range in waiting time for an appointment, from 1 day to 6 weeks.

As shown in Table V, less than half of those facilities willing to make an appointment could guarantee that the woman would be seen by a physician at the first appointment; almost one-third required at least one visit. The municipal health care system (hospitals and clinics) generally required two or more visits before a woman would see a doctor. The other public clinics and the nonpublic clinics were more able to facilitate a woman seeing a physician at first visit.

Among English-speaking callers, only 1 of the 53 who could make an appointment was told that not having insurance coverage was a problem; among Spanish-speaking callers, 8 of the 25 who could make an appointment were told the same thing (1.9% versus 32.0%, respectively). (Data not shown.)

TABLE V.
PERCENTAGE OF CLINICS REQUIRING MORE THAN ONE PRENATAL CARE VISIT BEFORE WOMAN IS SEEN BY PHYSICIAN, BY TYPE OF PROVIDER
NEW YORK CITY, 1992

(English only)

	N	NONE	ONE	TWO OR MORE
Total	53	41.5	32.1	26.4
Section 330 clinics	7	14.3	57.1	28.6
HHC/NFCCs*	5	20.0	20.0	60.0
Other public support clinics	12	41.7	41.7	16.7
Nonpublic support clinics	15	80.0	20.0	0.0
Municipal hospitals	3	0.0	0.0	100.0
Voluntary hospitals	11	27.3	36.4	36.4

Source: Prenatal Care Appointment Survey, conducted for CHAMP by Bureau of Maternity Services and Family Planning, New York City Department of Health, January 1992.

* HHC, Health and Hospitals Corporation; NFCC, Neighborhood Family Care Center.

Discussion

Directors of prenatal care clinics told us that January was a difficult month for serving clients: the preceding holidays meant vacation time for staff as well as canceled clinics putting an added stress on the clinics in January. Nevertheless, many of the clinics, at least among those who could be reached easily, met the standard of a 2-week wait, although the municipal health care system and the federally funded clinics required a 3-week wait. The waiting time for a first prenatal care appointment for women requiring public services is longer than desirable.

There are disturbing findings among the reasons women could not make an appointment. Only 1 in 5 Spanish-speaking women could be assisted by the receptionist or nearby clerical staff. Less than half the number of Spanish-speaking women, when compared with the English-speaking, could be accommodated. (Roughly one-third of the New York City births occur among Hispanic women, and a significant proportion occur among foreign-born Hispanics.) Too often no one answered the telephone or the line was busy, requiring persistence on the part of the pregnant woman. In addition, there seems to be an unwillingness to accept the results of pregnancy tests administered by others, creating an additional step for a woman. That a woman must register or become oriented to a clinic before an appointment can be made might be sound clinic practice. However, it is unclear whether the facilities acknowledge that requirement when promoting their services.

Among one-quarter of the providers a woman must make three visits to a clinic before being seen by a physician. It is unknown whether a risk assessment is made by a qualified health professional at the first or second visit, assuring that those at high risk receive appropriate triage. Of necessity, perhaps, those facilities under well-publicized financial stress—the municipal hospitals and clinics—put the greatest number of steps between the woman and a doctor.

Significantly more Spanish-speaking women than English-speaking women were told that not having insurance interfered with their getting an appointment. We want to assume that identical answers are given to English- and Spanish-speaking callers alike by

the same health care provider. The results of this survey, however, suggest there needs to be exploration as to whether or not Spanish-speaking women are being discriminated against for financial barriers, or whether problems arise in the translation of the question and interpretation of the clinic's answer.

Summary

This biopsy of the prenatal care system provides plain evidence of weaknesses within the infrastructure and details the inconveniences New York City women who rely on public services must face.

The unwillingness of some of the municipal clinics to accept pregnancy test results from their sister hospitals or the Department of Health's free-pregnancy testing program exemplifies one of the bureaucratic barriers in the system, and one which could be rectified easily given sufficient determination. Other bureaucratic barriers, such as the inability to schedule an appointment unless a woman is registered at the clinic, suggest the need for a media campaign urging women of reproductive age to register with a health care provider before becoming pregnant. The solution to the language barrier confronted by Spanish women requires a commitment to hiring bilingual clerical staff. Lastly, the problems of being placed "on-hold" or frequent busy signals and the high number of clinic visits made before seeing a physician can only be ameliorated by an increase in funding for prenatal care clinic staffing, for support staff and professionals alike.

The survey, conducted over the course of 2 weeks with available city staff and equipment, is a relatively inexpensive and effective method for evaluating the prenatal care system and should be repeated in order to document systematically the anecdotal reports shared by clinic administration and clinic patients alike.